TEXAS
Department of
Human Services

INTERIM COMMISSIONER
Anne Sapp

September 10, 2003

To: Community Care for the Aged and Disabled (CCAD) Primary Home Care (PHC) Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-35
Revision to Form 3052, and New Revision Schedule for Form 3040 and Form 3050-A

Long Term Care (LTC) Information Letter No. 03-13 contains the new Form 3052, Primary Home Care Practitioner's Statement of Medical Need, and instructions. Please note that revisions have been made to Form 3052 and the instructions. Primary Home Care (PHC) provider agencies should replace Form 3052 and instructions included with LTC Information Letter 03-13 with the versions attached to this letter.

LTC Information Letter 03-13 states "Forms 3040 and 3050-A will be revised no later than October 1, 2003." The Texas Department of Human Services (DHS) has decided to delay these form revisions. At this time, only the instructions to these forms are revised, as outlined in LTC Information Letter No. 03-13. Form 3040 and Form 3050-A will be revised in the future.

Please contact your contract manager if you have questions regarding this letter. Contract managers should contact Sarah Hambrick at (512) 438-2578.

Sincerely,

Signature on file

Marilyn Eaton
Lead Director
Long Term Care Services

ME:ck

Attachments

Texas Department
of Human Services

Form 3052
September 2003

PRIMARY HOME CARE

PRACTITIONER'S STATEMENT OF MEDICAL NEED

PROGRAM DESCRIPTION: Primary Home Care (PHC) is a Medicaid program administered by the Texas Department of Human Services (DHS). PHC provides NON-TECHNICAL ATTENDANT SERVICES to Medicaid eligible clients who reside at home. Attendants help clients with personal care tasks, meal preparation, and housekeeping tasks. Attendants are trained and supervised by non-medical personnel.

PART I, Client Information - To be completed by the provider agency

Client Name (Last, First, Middle)		Client No.
Client Address		
Provider Agency Name	Provider Agency Supervisor	Telephone No. (inc. A/C) ( )
Provider Agency Address		

PART II, Diagnosis(es) - To be completed by the Practitioner

MEDICAL DIAGNOSIS

PART III, Practitioner's Statement and Certification - To be completed by the Practitioner

NOTE - A PRACTITIONER'S STATEMENT OF MEDICAL NEED FOR PHC SERVICES IS REQUIRED. A TEXAS DEPARTMENT OF HUMAN SERVICES CASEWORKER AND A PROVIDER AGENCY NON-MEDICAL SUPERVISOR HAVE SCREENED THE CLIENT, AND THE CLIENT APPEARS TO NEED THIS SERVICE.

Statement of Medical Need

I hereby certify this client ☐ Does ☐ Does Not have a need for PHC services based on medical diagnosis(es).

Persons diagnosed with mental illness, mental retardation, or both are not considered to have established medical need based solely on such diagnosis. These persons may establish medical need through a related diagnosis.

If the Medical Need is Temporary, Enter the Estimated End Date (mo./yr.)

Comments: _____

I also certify that I am not a significant owner, partner and/or member of the provider agency requesting this practitioner's statement of medical need for PHC services.

X _____
Signature–Practitioner

Today's Date (mo./day/yr.)	Date of Verbal Statement (if app.) (mo./day/yr.)

Practitioner's Name (please type or print) ☐ MD ☐ DO ☐ APN ☐ PA	License No.	State

Practitioner's Address (Street, City, State, ZIP)	Telephone No. (inc. A/C) ( )

FORM 3052
Instructions

PRIMARY HOME CARE PRACTITIONER'S STATEMENT OF MEDICAL NEED

September 2003

PURPOSE

To be used by Primary Home Care Program provider agencies to request a statement of medical need from the client's practitioner.

When to Prepare

Form 3052 is completed for initial referrals for primary home care (PHC) and community attendant (CA) services, and for referrals for clients whose initial medical need for services was temporary.

Number of Copies

Prepare an original Form 3052 and a copy.

Transmittal

The provider agency completes Part I of Form 3052 and sends the original to the client's practitioner. The provider agency may send Form 3052 by mail or by facsimile, or hand-deliver Form 3052 to the practitioner.

The client's practitioner completes Part II of Form 3052 to attest to the client's need for services based on a medical diagnosis.

The practitioner returns Form 3052 to the provider agency and keeps a copy for his files.

The provider agency keeps the original Form 3052 and sends a copy of Form 3052 with Forms 3050-A and 2101 to the DHS regional nurse.

Form Retention

The provider agency must keep Form 3052 in the client's file for five years after creation.

Supply Source

This form must be photocopied from the *Community Care Provider Forms Manual*.

DETAILED INSTRUCTIONS

PART I, Client Information

The provider agency must complete PART I.

Client Name — Enter the client's full name as it appears on Form 2101.

Client No. — Enter the client number as it appears on Form 2101.

Client Address — Enter the client's home address.

Provider Agency Name — Enter the complete name of the provider agency requesting the physician's order.

Provider Agency Supervisor — Enter the complete name of the provider agency supervisor assigned to the client.

Telephone No . — Enter the supervisor's complete office telephone number, including the area code.

Provider Agency Address — Enter the provider agency's address.

PART II, Diagnosis(es)

The client's practitioner must complete PART II.

Medical Diagnosis — The practitioner lists the primary diagnosis that causes the client to need PHC services first. The practitioner may list other applicable diagnosis(es). The provider agency must ensure the practitioner completes at least the primary diagnosis.

PART II, Practitioner's Statement and Certification

The client's practitioner must complete PART III, with the exception of the item "Date of Verbal Statement (if app.)". The provider agency supervisor may fill in the date he or she obtained a verbal statement of medical need from the practitioner.

Statement of Medical Need — Check the appropriate box indicating whether or not the client has a need for PHC services based on a medical diagnosis(es).

If the Medical Need is Temporary, Enter the Estimated End Date — Enter the month and year the client's medical need for PHC services is estimated to end. This is only applicable if the need for services is expected to last less than one year or is not ongoing.

Comments — The practitioner enters any appropriate comments regarding the client's need for PHC services.

Signature – Practitioner — The practitioner signs his or her name, including credentials. The practitioner is certifying that:

- the client does or does not have a medical need for PHC services;
- the medical need is permanent or temporary. If the medical need is temporary, the practitioner is certifying the estimated end date of medical need; and
- that the practitioner is not a significant owner, partner and/or member of the provider

agency.

Today's Date — The practitioner enters the date he or she signs the statement.

Date of Verbal Statement (if app) — The provider agency supervisor enters the date the practitioner gave a verbal statement of medical need, if applicable. If the date is entered incorrectly, the supervisor who made the error must line through the verbal order date, write in the word "error," and sign or initial the date correction.

Practitioner's Name — Enter the first and last name of the practitioner providing the statement of medical need. Check M.D., D.O. (Doctor of Osteopathy), A.P.N. (Advance Practice Nurse), or P.A. (Physician's Assistant) as appropriate.

License Number — Enter the license number of the practitioner providing the statement of medical need.

State — If the practitioner is not licensed in Texas, indicate the state of licensure. If the practitioner is licensed in Texas, no entry is needed.

Practitioner's Address — Enter the practitioner's complete address, including ZIP code.

Telephone No. (inc. A/C) — Enter the practitioner's office telephone number, including area code.